DCH/LCH-500 (12/04)

Michigan Department of Community Health
Board of Chiropractic
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

CHIROPRACTOR RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Chiropractic. Questions regarding your application can be directed to the Michigan Board of Chiropractic at (517) 335-0918 three weeks after the date you sent the application. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid. Please allow 4-6 weeks processing time.

CHIROPRACTOR BY RELICENSURE

1. Completed the application and return it to the Board of Chiropractic with the appropriate fee. A check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany the application. An application accompanied by the appropriate fee is valid for two years. Applications received without a fee will be returned.

2. Submit either evidence of completion of 36 hours of board-approved continuing education within the three years immediately preceding the date of this application with not less than 24 of those hours in courses on chiropractic adjusting techniques. **OR**

   Submit evidence of having been continuously licensed in another state during the three-year period immediately preceding the date of this application.

3. Send the enclosed Verification of Licensure or Registration form to any other state where you are currently or have ever held a permanent chiropractic license, the form may be duplicated as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required before sending them the form for completion. The verification form must be sent to the Michigan Board directly form the states(s) where you have been licensed.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Chiropractic in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Chiropractic in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A TWO-YEAR PERIOD.

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APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only

License Number

Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

☐ **Relicensure Fee: $140.00 71-2301-06**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number ( )
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Has your Michigan chiropractic license been lapsed more than three years? ☐ No ☐ Yes	Michigan Permanent I.D. Number/License and Expiration Date	

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No

Name

7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

List the state(s) in which you hold or have ever held a license or registration for your profession, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure or registration directly to this board office. (Attach additional sheets if necessary.)**

State	License Number	Date of Issue	How obtained (Endorsement or examination)

In order to become relicensed as a chiropractor in Michigan you must either:

1. Submit evidence of completion of 36 hours of board-approved continuing education within the three years immediately preceding the date of this application with not less than 24 hours in courses on chiropractic adjusting techniques; **OR**

2. Submit evidence of having been continuously licensed in another state during the three year period immediately preceding the date of this application.

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

DCH/HLD-001 (12/04)

Michigan Department of Community Health
Bureau of Health Professions
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Lansing, MI 48909
www.michigan.gov/healthlicense

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date

Basis for Issuance of License:

☐ Examination - Please indicate type of exam (National, Regional, State, etc.) _____

☐ Endorsement - Please indicate name of state _____

License Status
☐ Current ☐ Lapsed ☐ Inactive

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?
☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.